DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11008 (Rev. 01/02)

STATE OF WISCONSIN
(800) 947-9627

PRIOR AUTHORIZATION / THERAPY ATTACHMENT

SECTION A. RECIPIENT / PROVIDER INFORMATION

1. Recipient's Name — Last	First	MI	2. Recipient's Medicaid ID Number	3. Recipient's Age

4. Therapist's Name & Credentials	5. Therapist's Medicaid Provider No.	6. Therapist's Telephone No.

7. Referring / Prescribing Physician's Name	8. Requesting Prior Authorization (PA) For
	☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

9. Total Time Per Day Requested	10. Total Sessions Per Week Requested

11. Total Number of Weeks Requested	12. Requested Start Date

SECTION B. PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

INSTRUCTIONS: Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

SECTION C. BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

INSTRUCTIONS: Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION D. PERTINENT THERAPY INFORMATION

1. INSTRUCTIONS: Document the chronological history of treatment for the diagnoses (identified under Section B), dates of those treatments, and the recipient's functional status following those treatments.

Provider Type (e.g., OT, PT, ST)	Dates of Treatment	Functional Status after Treatment

2. INSTRUCTIONS: List other service providers that are currently accessed by the recipient for those treatment diagnoses identified under "B", (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include phone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.

3. INSTRUCTIONS: Check the appropriate box and circle the appropriate form, if applicable.

- ☐ The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/Individual Program Plan (IPP) is attached to this PA request.
- ☐ The current IEP/IFSP/IPP is attached to PA Number _____.
- ☐ There is no IEP/IFSP/IPP because_____
  _____.
- ☐ Co-treatment with another therapy provider is within the plan of care.
- ☐ Referenced report(s) is attached (list any report[s]) _____.

SECTION E. EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

INSTRUCTIONS: Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- ☐ Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- ☐ Comprehensive initial evaluation submitted with PA number _____.
- ☐ Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- ☐ Current re-evaluation submitted with PA number _____.

SECTION F. PROGRESS

INSTRUCTIONS: Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date (/ /)	Status as of Date of PA Request / Date (/ /)

(If this information is concisely written in other documentation prepared for your records, attach and write "see attached" in the space above.)

SECTION G. PLAN OF CARE

INSTRUCTIONS: Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and

(1) the therapist required skills/treatment techniques that will be used to meet each goal; and
(2) designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space above.)

SECTION H. REHABILITATION POTENTIAL

INSTRUCTIONS: Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

(3) The recipient/recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

(4) It is estimated this episode of care will end (provide approximate end time)

SIGNATURE – Physician	Date Signed
SIGNATURE – Providing Therapist	Date Signed
SIGNATURE – Recipient or Recipient Caregiver (optional)	Date Signed

Reset Form